

## MONTANA CENTRAL TUMOR REGISTRY ABSTRACTING FORM

Form TR-002  
Revised 5/08

Reporting Facility <b>Montana Community Hospital</b>		Abstracted By <b>Mary Abstractor</b>		Date Abstracted <b>5/8/08</b>		Date Received by MCTR	
<b>PATIENT INFORMATION</b>							
Facility # <b>484</b>		Accession # <b>2007-00049</b>		Sequence # <b>02</b>		Date First Contact <b>4/6/07</b>	
				Medical Record Number <b>M-303490</b>			
Name of Patient Last <b>Anderson</b>		First <b>Margaret</b>		Middle <b>Meredith</b>		Maiden <b>Miller</b>	
				Alias <b>Marnie</b>		Primary Payer <b>M-care/BC</b>	
Social Security Number <b>555-55-5555</b>		Date of Birth <b>10/15/1923</b>		Facility Referred From <b>None</b>		Facility Referred To <b>City Radiation Center</b>	
Race <b>White</b>	Hispanic Origin <b>Non-Hispanic</b>	Sex <b>Female</b>	Age <b>84</b>	Marital Status <b>Married</b>	Name of Spouse/Parent <b>George</b>	Place of Birth <b>WA</b>	
Physical Address No & Street <b>1111 West Center Lane</b>		City <b>Somewhere</b>		County <b>Beaverhead</b>		State <b>MT</b>	Zip Code <b>59888</b>
Telephone Number <b>(406) 555-5555</b>		Family History of Cancer (Who/Type) <b>Father had colon ca</b>		Tobacco History <b>Never smoked</b>		Alcohol History <b>1 drink/week</b>	
Usual Occupation <b>Accountant</b>				Usual Industry <b>Higgins Accounting Firm</b>			
Follow-Up Contact - Name (not spouse) <b>Curt Anderson</b>		Relationship <b>Son</b>		No & Street <b>303 Nevada St</b>		City <b>Sometown</b>	State <b>AZ</b>
						Zip Code <b>85888</b>	Telephone Number <b>(999) 666-6666</b>
<b>CANCER INFORMATION</b>							
Date of Initial Diagnosis <b>4/6/07</b>		Primary Site <b>Breast, UOQ</b>		Laterality <b>Right</b>		Other Primary Tumors <b>01-Cervix dx'd 1962 (not reported)</b>	
Place of Diagnosis (if diagnosed elsewhere, please describe place) <input checked="" type="checkbox"/> This Hospital <input type="checkbox"/> Other Hospital <input type="checkbox"/> Physician's Office <input type="checkbox"/> Unknown <input type="checkbox"/> Other _____				Diagnostic Confirmation <input checked="" type="checkbox"/> Histology <input type="checkbox"/> Cytology <input type="checkbox"/> Microscopic <input type="checkbox"/> Lab Test <input type="checkbox"/> Visual <input type="checkbox"/> X-ray <input type="checkbox"/> Clinical <input type="checkbox"/> Unknown			
<b>Diagnostic Summary</b> (document details of physical evaluation, pathology, scopes, x-rays/scans, and lab tests including date and name of procedure(s), slide #, facility, specimen, histology, grade, behavior, tumor size, extension, surgical margins, LN's involved and examined). <b>Attach copies of surgical or pathology reports and discharge summaries, if necessary.</b> <b>4/4/07 Dr. Miller, routine appt with breast exam; palpable lump detected. Pt has hx of lumpy breasts.</b> <b>4/6/07 Mammogram at MCH: approx 1 cm mass in ROUQ suspicious for malignancy.</b> <b>4/7/07 MCH, biopsy Rt UOQ Breast, S07-6339: Ductal adenoca, grade 2/3.</b> <b>4/14/07 Lumpectomy at MCH, S07-7846: Invasive ductal carcinoma; grade 2/3; 1.2 x 1.0 cm tumor size; cancer involves 0 of 20 axillary lymph nodes; final margins negative.</b> <b>4/14/07 ER/PR 1+ (positive); HER2/NEU not detected.</b>							
<b>Collaborative Staging</b> Size of Tumor <b>1.2 cm</b> Describe Size <b>1.0 x 1.2 cm per path report</b> Extension <b>Confined to Breast, 0/20 positive lymph nodes</b> No. of Regional Lymph Nodes Positive <b>00</b> No. of Regional Lymph Nodes Examined <b>20</b> Sites of Distant Metastases <b>None</b> Substantiate Stage <b>neg LN's - physician states T1c, N0, Stage I</b>				<b>SEER Summary Staging</b> <input type="checkbox"/> In-situ <input checked="" type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> Distant <input type="checkbox"/> Unknown <b>AdCC Staging</b> <input type="checkbox"/> Clinical <input checked="" type="checkbox"/> Pathological T <b>1C</b> N <b>0</b> M <b>0</b> Stage Group <b>I</b>			
<b>TREATMENT INFORMATION</b>							
<b>Cumulative Treatment Summary</b> (document details of surgery, radiation, or systemic therapy including dates, places, and types; if no therapy is given, record reason) <b>4/7/07 Biopsy at MCH.</b> <b>4/14/07 Lumpectomy with axillary lymph node dissection at MCH.</b> <b>5/1/07 Beam radiation started at Montana Cancer Center, completed 6/15/07. Notes document 5500 cGy given for 25 days.</b>							
<b>OUTCOMES</b>							
<b>Status</b> Date of Last Contact or Death <b>4/13/08</b> Vital Status <input checked="" type="checkbox"/> Alive <input type="checkbox"/> Dead Cancer Status <input checked="" type="checkbox"/> No Evidence <input type="checkbox"/> Evidence <input type="checkbox"/> Unknown Cause of Death _____ Autopsy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Place of Death _____		<b>Recurrence</b> Recurrence Date _____ Recurrence Type <input type="checkbox"/> In-situ <input type="checkbox"/> Local <input type="checkbox"/> Regional <input type="checkbox"/> Distant <input type="checkbox"/> Unknown Describe _____			<b>Comorbidities and Complications (ICD-9-CM)</b> 1. <b>496 COPD</b> 2. <b>25000 DMII</b> 3. <b>4019 HTN</b> 4. _____ 5. _____ 6. _____		
Physician - Surgeon <b>Dr. Mark Surgeon</b>		Physician - Follow-Up <b>Dr. Fred Miller</b>		Physician - Managing		Physician - 3	
						Physician - 4	

Fax to Montana Central Tumor Registry, (406) 444-6557